U.S. Department of Labor

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Issue Date: 03 April 2007

Case No.: 2006-BLA-05804

In the Matter of

E.A.
Claimant

v.

DRUMMOND COMPANY, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

Patrick K. Nakamura, Esquire
For Claimant

Robin A. Adams, Esquire
For Employer

Before: ROBERT D. KAPLAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

[1] The regulations cited are the amended regulations that became effective on January 19, 2001. 20 C.F.R. Parts 718 and 725.

On June 6, 2006, this case was referred to the Office of Administrative Law Judges for a formal hearing. Subsequently, the case was assigned to me. The hearing was held before me in Birmingham, Alabama, on December 19, 2006, where the parties had full opportunity to present evidence and argument. Employer was granted additional time to submit rebuttal evidence. (T 8).[2] Employer submitted a medical report from Dr. A. David Russakoff on January 30, 2007, which is hereby received into evidence as Employer's Exhibit 5 ("EX 5"). Employer filed a brief on March 1, 2007. Claimant filed a brief on March 7, 2007. The decision that follows is based upon an analysis of the record, the arguments of the parties and the applicable law.

I. ISSUES

The parties stipulated to 34 years of coal mine employment. (T 5). I find the record supports this stipulation. The following issues are presented for adjudication:

1) whether Claimant has pneumoconiosis;

2) whether Claimant's pneumoconiosis arose out of his coal mine employment;

3) whether Claimant is totally disabled; and

4) whether Claimant's total disability is due to pneumoconiosis.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Claimant filed this claim for benefits on March 2, 2005. (DX 2). On February 23, 2006, the District Director awarded benefits. (DX 23). Subsequently, Employer requested a formal hearing. (DX 24).

B. Factual Background

Claimant was born on August 15, 1936. He married J.C. on February 5, 1954 and she is his only dependent for purposes of augmentation of benefits. (DX 2). Claimant provided testimony at the hearing and submitted several statements regarding his previous coal mine employment.

Regarding his prior coal mine work, Claimant testified that he worked as a coal scrapper, blast hole loader, and drill helper. Claimant also worked on an electric shovel for approximately fourteen years, operating the machine to scoop up rock and dirt. (T 16-18). Claimant then worked as a supervisor for one year. Claimant went to work for Employer in 1980 as a pit foreman and then coal haul foreman until he was terminated. (T 19-20). As coal haul foreman,

[2] The following abbreviations are used herein: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; and "T" refers to the transcript of the December 19, 2006 hearing.

he was responsible for ensuring that the coal was clean enough to go directly to the coke plant. (T 20).

Presently, Claimant complains of shortness of breath and fatigue. Claimant testified he has been on oxygen for almost two years and uses a golf cart to move around. He cannot walk or climb steps and becomes short of breath taking a shower. (T 22-23). Claimant stated he began seeing Dr. Flippo for his breathing problems. Dr. Flippo recommended Claimant have a "heart cath" which showed some blockage in his heart. The physician told Claimant his heart problems were probably causing the shortness of breath. Claimant had heart surgery but his breathing did not improve. Dr. Flippo referred Claimant to Dr. Vines, a pulmonologist. (T 23-24). Claimant stated he has been treating with Dr. Vines for two years. (T 25). Claimant testified he began smoking while in the Army and smoked a pack of cigarettes per day until the 1970s. (T 25).

C. Entitlement

Because this claim was filed after the effective date of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under Part 718 standards. § 718.2. In order to establish entitlement to benefits under Part 718, Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the miner is totally disabled, and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

D. Relevant Medical Evidence

The record shows that Claimant was admitted to Medical Center East on July 23, 2001 because of exertional shortness of breath and exertional chest pain. Claimant was diagnosed with coronary artery disease with angina pectoris and left main coronary stenosis. Claimant's secondary diagnoses included hypertension, adult onset diabetes mellitus, hypothyroidism, esophageal spasms, benign prostatic hypertrophy, and osteoarthritis. Claimant underwent a coronary artery bypass grafting, which he tolerated well. Claimant was discharged on July 28, 2001. (DX 12).

The record also contains reports of procedures Claimant underwent at Medical Center East. On October 15, 2002, Claimant had a thorax CT scan, which showed bibasilar streaky density. The etiology of the density was unclear but speculated to be fibrosis or interstitial edema related to congestive heart failure. On November 14, 2002, Claimant underwent a cardiac ultrasound for his shortness of breath. The test showed borderline left ventricular hypertrophy, moderate bilateral enlargement, aortic sclerosis, mitral fibrosclerosis, mild mitral regurgitation, and mild tricuspid regurgitation. Claimant had an echocardiogram on December 4, 2003, which showed right ventricle and left atrium enlargement, moderate tricuspid insufficiency, and aortic valve calcifications. On December 5, 2003, Claimant underwent a stress test, which revealed possible multi-vessel coronary disease with multiple regions of ischemia. Claimant had a cardiac catheterization on January 6, 2004 that revealed left main coronary artery disease. (DX 12).

The record contains treatment notes from Dr. Michael Simpson. Dr. Simpson examined Claimant on September 24, 2001 and noted Claimant's complaint of dyspnea on exertion. Dr. Simpson stated Claimant's dyspnea was probably due to high blood pressure. Claimant's lungs were clear on examination. Claimant's next examination with Dr. Simpson occurred on March 27, 2002. Claimant again reported shortness of breath on exertion. Dr. Simpson noted Claimant had gained weight, which was probably related to the shortness of breath. On October 9, 2002, Claimant again reported dyspnea with exertion as well as fatigue. Dr. Simpson noted Claimant's progressive weight gain and suspected Claimant had sleep apnea. The final office visit note, dated July 7, 2003, stated Claimant was "doing reasonably well." Dr. Simpson also noted Claimant had a pulmonary evaluation with Dr. Ross and "it was felt he may have had possibly 'burned out' sarcoidosis." (DX 12).

The record also includes treatment notes from Dr. Flippo. On January 16 and 24, 2002, Dr. Flippo noted Claimant was treated for shingles. On October 10, 2002, Claimant was examined by Dr. Flippo and complained of shortness of breath and some sputum production. The physician stated Claimant's pulmonary function tests were normal. Claimant had a follow up visit on October 24, 2002 for persistent dyspnea on exertion and cough. Claimant's next examination on March 17, 2003 showed no abnormalities and Claimant had no pulmonary complaints. On May 19, 2003, Claimant reported feeling nauseated after walking and wheezing at night. Dr. Flippo noted that an evaluation by Dr. Ross for an abnormal CT scan was "apparently negative." The physician also stated he was "concerned [Claimant] may have undiagnosed asthma." On May 27, 2003, Claimant reported no dyspnea but had a moderate cough productive of yellow and green sputum. Dr. Flippo stated a chest X-ray on the same date showed increased markings in lower lung fields and cardiomegaly. The physician stated Claimant's dyspnea was "essentially resolved" on June 2, 2003. (CX 5).

At his next examination on November 3, 2003, Claimant complained of abdominal pain but had no pulmonary complaints. Dr. Flippo noted on November 24, 2003 that Claimant had a recent emergency room visit for fluid retention and pulmonary edema. Claimant reported no increased dyspnea on exertion. On December 16, 2003, Dr. Flippo stated a recent nuclear stress test showed evidence of multi-vessel disease. The physician recommended Claimant have a catheterization. On February 24, 2004, Dr. Flippo stated he suspected Claimant's shortness of breath was related to "mild pulmonary disease combined with reduced stamina and weight." Claimant next saw Dr. Flippo on June 22, 2004. He reported his shortness of breath was a little better and he did not have any chest pain, orthopnea, cough, or sputum. On September 14, 2004, Claimant had no upper respiratory symptoms and no orthopnea.

Claimant's next examination with Dr. Flippo occurred on January 31, 2005. He reported gradually worsening shortness of breath on exertion but no cough or sputum production. Dr. Flippo stated Claimant had "known interstitial lung disease." The physician found bilateral crackles on examination of the lungs. On February 7, 2005, Claimant reported he was doing a little better. On examination, Dr. Flippo noted decreased breath sounds and bilateral crackles. The physician referred Claimant to Dr. Vines for a pulmonary evaluation. On February 25, 2005, Dr. Flippo stated that Dr. Vines had diagnosed Claimant with coal worker's pneumoconiosis. The physician also noted Claimant continued to have dyspnea with moderate

exertion and moderate cough. The physical examination showed decreased breath sounds and mild rhonchi.

On May 6, 2005, Claimant reported moderate cough with yellow and green sputum and shortness of breath. The physical examination revealed no abnormalities. On May 27, 2005, Claimant was examined for burning in his lower extremities and knee pain. On May 31, 2005 and June 6, 2005, Claimant was treated for gout. On October 4, 2005, Dr. Flippo stated Claimant had pulmonary fibrosis and was oxygen dependent. The physical examination revealed decreased breath sounds and crackles bilaterally. Dr. Flippo treated Claimant for anxiety on October 12, 2005. On December 13, 2005, Dr. Flippo stated Claimant had dyspnea with minimal exertion, moderate, minimally productive cough. The physical examination revealed moderate rhonchi and bilateral crackles. At his March 20, 2006 examination, Claimant complained of dyspnea with moderate exertion. Dr. Flippo noted decreased breath sounds and an expiratory wheeze. The last treatment note from Dr. Flippo dated July 20, 2006 noted Claimant was feeling fine and his dyspnea on exertion was stable. The physician stated Claimant had no increase in cough or sputum production and was staying "very active around the house and farm." (CX 5).

The record also contains treatment notes from Dr. T. Alan Vines. Claimant's initial visit with Dr. Vines occurred on February 14, 2005. Dr. Vines noted Claimant was experiencing shortness of breath and occasional wheezing and had been on oxygen for two weeks. The physician's examination revealed bibasilar fibrotic rales. Dr. Vines stated Claimant had "interstitial lung disease suspect primarily coal dust pneumoconiosis but may have components of asbestosis or silicosis." The physician diagnosed Claimant with respiratory failure, coronary artery disease, hypertension, and diabetes mellitus. At Claimant's follow up examination on March 14, 2005, Dr. Vines noted Claimant had been stable over the last month. The examination again showed bibasilar fibrotic rales. On July 12, 2005, Dr. Vines stated Claimant's only symptom was dyspnea on exertion and his pulmonary function test showed stable lung volumes. On January 11, 2006, Dr. Vines noted Claimant's breathing was stable with no increase in dyspnea on exertion. On July 26, 2006, Dr. Vines stated Claimant's only symptom was dyspnea on exertion walking uphill, up stairs, or in the shower. The physician noted Claimant had a stable X-ray and continued home oxygen. (CX 4).

E. Elements of Entitlement

1. Presence of Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at § 718.202(a)(1) through (a)(4):

(1) X-ray evidence. § 718.202(a)(1).

(2) Biopsy or autopsy evidence. § 718.202(a)(2).

(3) Regulatory presumptions. § 718.202(a)(3).

a) § 718.304 - Irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.

b) § 718.305 - Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.

c) § 718.306 - Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one of more coal mines prior to June 30, 1971.

(4) Physician's opinions based upon objective medical evidence § 718.202(a)(4).

X-ray evidence, § 718.202(a)(1)

Under § 718.202(a)(1), the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with § 718.102. The current record contains the following chest X-ray evidence.[3]

DATE OF X-RAY	DATE READ	EX. NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	I.L.O. CLASS
05/09/05	05/20/05	DX 10	Dr. Nath	BCR, B	0/0
05/09/05	11/30/05	EX 2	Dr. Wheeler	BCR, B	0/0
10/10/05	10/10/05	EX 1	Dr. Goldstein	B-reader	2/1
10/10/05	10/24/06	EX 3	Dr. Wheeler	BCR, B	0/0
10/10/05	11/19/06	CX 1	Dr. Cappiello	BCR, B	2/2
10/10/05	11/27/06	CX 2	Dr. Ahmed	BCR, B	1/1

[3] A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51. A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii) (2001).

It is well-established that the interpretation of an X-ray by a B-reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985); Martin v. Director, OWCP, 6 B.L.R. 1-535, 537 (1983); Sharpless v. Califano, 585 F.2d 664, 666-7 (4th Cir. 1978). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). In addition, a judge is not required to accord greater weight to the most recent X-ray evidence of record, but rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to be considered. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

The film taken on May 9, 2005 was interpreted as negative by Drs. Nath and Wheeler. Dr. Barrett read the film for quality only. Consequently, I find this X-ray is negative for the presence of pneumoconiosis.

The film taken on October 10, 2005 was interpreted as negative by Dr. Wheeler. Conversely, the film was interpreted as positive by Drs. Goldstein, Cappiello, and Ahmed. As the positive interpretations exceed the negative interpretation, I find that the chest X-ray is positive for the presence of pneumoconiosis.

Considering all of the X-ray evidence together, I note that the two X-rays are contemporaneous in that they were taken only five months apart. I find that the X-ray evidence is in equipoise and does not support a finding of the presence of pneumoconiosis.

Biopsy or autopsy evidence, § 718.202(a)(2)

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is unavailable here, because the current record contains no such evidence.

Regulatory presumptions, § 718.202(a)(3)

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. § 718.305(e) Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physicians' opinions, § 718.202(a)(4)

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth as follows in subparagraph (a)(4):

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Section 718.204(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis." Section 718.201 (a)(1) and (2) defines clinical pneumoconiosis and legal pneumoconiosis. Section 718.201(b) states:

> [A] disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

The record contains the following physician's opinions.

Dr. Zakir N. Khan

Dr. Zakir N. Khan (Board-certified in Internal Medicine)[4] examined Claimant on April 25, 2005 and issued a report on May 25, 2005. Dr. Khan also issued a supplemental report on August 9, 2005. The physician credited Claimant with 34 years of coal mine employment and considered a smoking history of one pack of cigarettes per day for 22 years. Claimant complained of daily wheezing, dyspnea on walking one-half block, daily cough, two-pillow orthopnea, and ankle edema. The physical examination revealed no significant abnormalities. Dr. Khan noted the chest X-ray dated May 9, 2005 showed streaking opacities in both lower lungs. The pulmonary function test revealed a restrictive lung disease with no bronchodilator response and impaired membrane function. The physician stated the arterial blood gas study showed Claimant has hypoxemia at rest, which worsens with exercise. Dr. Khan opined Claimant has pneumoconiosis manifesting as a restrictive lung disease based on history, chest X-ray, pulmonary function test, and arterial blood gas study. The physician also diagnosed Claimant with myocardial ischemia based on history and hypertension based on history and physical examination. Dr. Khan concluded the etiology of Claimant's pneumoconiosis was due to coal mine employment and tobacco use. (DX 10). In a supplemental report dated August 9, 2005, Dr. Khan stated that he defined pneumoconiosis "as any chronic respiratory or pulmonary condition due in whole or part to dust exposure in coal mine employment." The physician stated both coal dust and tobacco use contributed to Claimant's pulmonary condition but could not say the two factors were equal contributors. (DX 11).

[4] Source: American Board of Internal Medicine, (https://www.abim.org/who/index.shtm).

Dr. Allan R. Goldstein

Dr. Allan R. Goldstein (Board-certified in Internal Medicine and Pulmonary Disease) examined Claimant on October 10, 2005 and issued a report on November 3, 2005. Dr. Goldstein credited Claimant with 34 years of coal mine employment and considered a smoking history of less than one pack of cigarettes per day for 20 years. Claimant complained of shortness of breath, which has progressed such that he cannot walk fast, walk up hill, or do any heavy work without becoming short of breath. The physical examination revealed fine rales from the mid lung fields down but no rhonchi or wheezes. Dr. Goldstein noted the chest X-ray showed "changes in both lower lung fields that appear to be linear in interstitial changes of profusion 2/1." The physician stated the pulmonary function test results were consistent with a restrictive defect with abnormal diffusion. Dr. Goldstein stated that Claimant "does not have the typical picture of coal workers' pneumoconiosis or silicosis." The physician stated he would expect to see nodular disease in the upper lung fields but Claimant has abnormalities in the lower lung fields. Dr. Goldstein issued a supplemental report on December 19, 2005 after reviewing the November 30, 2005 chest X-ray, treatment records from Drs. Simpson and Flippo, and Dr. Kahn's examination report. The physician opined that Claimant has an interstitial process but did not find evidence that Claimant has pneumoconiosis. (EX 1).

Dr. A. David Russakoff

Dr. A. David Russakoff (Board-certified in Internal Medicine and Pulmonary Disease) reviewed Claimant's prior medical records and issued a report dated November 13, 2006. (EX 4). Dr. Russakoff reviewed Claimant's hospital records from Medical Center East, treatment records from Dr. Simpson, Dr. Khan's examination report, Dr. Goldstein's examination report, and treatment records from Dr. Flippo. Dr. Russakoff opined that Claimant has a respiratory problem as shown by his need for home oxygen, abnormal pulmonary function tests, chest X-rays and CT scans. However, the physician concluded Claimant does not have coal workers' pneumoconiosis. Dr. Russakoff noted that the physicians who interpreted Claimant's X-rays did not find evidence of "the usual rounded, regular opacities of coal workers' pneumoconiosis usually seen in the upper lung zones." Additionally, the physician stated that Claimant's pulmonary function tests showed a restrictive lung impairment and not an obstructive impairment. Dr. Russakoff opined that coal workers' pneumoconiosis typically produces an obstructive impairment not a pure restrictive impairment. Finally, Dr. Russakoff asserted that the absence of disease in Claimant until more than 10 years after exposure, and then rapid deterioration once disease was detected, is very atypical of coal workers' pneumoconiosis. The physician concluded these factors indicate a "more aggressive interstitial lung disease of the auto-immune variety." (EX 4).

Dr. T. Alan Vines

Dr. T. Alan Vines (Board-certified in Internal Medicine and Pulmonary Disease) issued a report on November 27, 2006. Dr. Vines credited Claimant with 34 years of coal mine employment and considered a smoking history of one pack of cigarettes per day for 22 years. The physician's report consisted entirely of answers to two questions. Dr. Vines checked off the answer "Yes" for the following question.

> In your opinion does [Claimant] have "a chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment?

The second question is as follows.

> If your answer is yes, the contribution of his pneumoconiosis (defined as "chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.") to his overall impairment can be characterized as follows:

Dr. Vines placed a check mark beside the answer, "a major contributor to his overall impairment." (CX 3).

I find Dr. Khan's opinion that Claimant has pneumoconiosis is reasoned and well-documented. An opinion is well-documented and reasoned when it is based on evidence such as physical examinations, symptoms, and other adequate data that support the physician's conclusions. See Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987); Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295 (1984). Dr. Khan relied on Claimant's coal mine employment and smoking histories, physical examination, chest X-ray, and objective medical testing in reaching his conclusion.

I also find Dr. Goldstein's opinion that Claimant does not have pneumoconiosis is reasoned and well-documented. Dr. Goldstein based his conclusion on Claimant's coal mine employment and smoking histories, physical examination, chest X-ray, objective medical testing, and prior medical records.

I also find Dr. Russakoff's opinion that Claimant does not have pneumoconiosis is reasoned and well-documented. Dr. Russakoff considered Claimant's coal mine employment and smoking histories. The physician also relied on Claimant's prior medical records in reaching his conclusion.

I find Dr. Vines' opinion is unreasoned and not documented. A medical opinion that is undocumented or unreasoned may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989); see also Duke v. Director, OWCP, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how the underlying documentation supports his or her diagnosis). Dr. Vines provided no explanation for his conclusion and did not describe which evidence supports his opinion. Therefore, I find Dr. Vines' opinion that Claimant has pneumoconiosis is entitled to no weight.[5]

[5] Although the evidence shows that Dr. Vines is Claimant's treating physician, I do not give controlling weight to his opinion as relevant evidence in the record substantially contradicts the physician. § 718.104(d)(5).

Weighing the contrasting opinions, I note that Drs. Khan, Goldstein, and Russakoff are all Board-certified in Internal Medicine. Drs. Goldstein and Russakoff have the additional, relevant, qualification of board certification in Pulmonary Disease. Additionally, both Drs. Goldstein and Russakoff had the opportunity to review Claimant's prior medical evidence. Thus, the physicians had more extensive medical information on which to base their conclusions than Dr. Khan. Therefore, I find the opinions of Drs. Goldstein and Russakoff are entitled to greater weight. Accordingly, I find the medical opinion evidence does not support a finding of pneumoconiosis.

As discussed above, the X-ray evidence does not support a finding of the presence of pneumoconiosis. The medical opinion evidence also does not support a finding of the presence of pneumoconiosis. Therefore, I find Claimant has failed to establish this element of entitlement.

2. Pneumoconiosis Arising Out of Coal Mine Employment

As Claimant has failed to establish the presence of pneumoconiosis under § 718.202(a), Claimant cannot establish that the miner had pneumoconiosis arising out of coal mine employment pursuant to § 718.203.

3. Total Disability

Claimant must establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) provides as follows:

> [A] miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner
>
> (i) From performing his or her usual coal mine work; and
> (ii) From engaging in gainful employment . . . in a mine or mines . . .

§ 718.204(b)(1).

Nonpulmonary and nonrespiratory conditions which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability under the Act. § 718.204(a); see also, Beatty v. Danri Corp., 16 B.L.R. 1-1 (1991), aff'd as Beatty v. Danri Corp. & Triangle Enterprises, 49 F.3d 993 (3d Cir. 1995).

Claimant may establish total disability in one of four ways: pulmonary function study; arterial blood gas study; evidence of cor pulmonale with right-sided congestive heart failure; or reasoned medical opinion. § 718.204(b)(2)(i-iv). Producing evidence under one of these four ways will create a presumption of total disability only in the absence of contrary evidence of greater weight. Gee v. W.G. Moore & Sons, 9 B.L.R. 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant

bearing the burden of establishing total disability by a preponderance of the evidence. Rafferty v. Jones & Laughlin Steel Corp., 9 B.L.R. 1-231 (1987).

In order to establish total disability through pulmonary function tests, the FEV_1 must be equal to or less than the values listed in Table B1 of Appendix B to this part and, in addition, the tests must also reveal either: (1) values equal to or less than those listed in Table B3 for the FVC test, or (2) values equal to or less than those listed in Table B5 for the MVV test or, (3) a percentage of 55 or less when the results of the FEV_1 test are divided by the results of the FVC tests. § 718.204(b)(2)(i)(A-C). Such studies are designated as "qualifying" under the regulations. Assessment of pulmonary function study results is dependent on Claimant's height, which was most frequently noted to be 70 inches. I therefore used that height in evaluating the studies. Protopappas v. Director, OWCP, 6 B.L.R. 1-221 (1983).

The current record contains the pulmonary function studies summarized below.

DATE	EX. NO.	PHYSICIAN	AGE	FEV_1	FVC	MVV	FEV_1/FVC	EFFORT	QUALIFIES
02/14/05	CX 5	Dr. Vines	68	2.23	2.79	68	80%	Good	No
04/25/05	DX 10	Dr. Khan	68	2.13 2.25*	2.65 2.70*	96 94*	80% 83%*	Good Good*	No No*
10/10/05	EX 1	Dr. Goldstein	69	1.93	2.34	74	82%	Good	No

*post-bronchodilator

February 14, 2005 Pulmonary Function Study

This study produced non-qualifying values under the regulations. § 718.204(b)(2)(i). The pulmonary function report contained the required flow-volume loop and tracings and a notation that Claimant's efforts were acceptable. Additionally, no evidence was submitted that challenged the validity of the test results. Therefore, I find that the February 14, 2005 pulmonary function test is valid.

April 25, 2005 Pulmonary Function Study

This study produced values that were non-qualifying under the regulations. § 718.204(b)(2)(i). The pulmonary function report contained the required flow-volume loop and tracings and a notation that Claimant's efforts were acceptable. Additionally, no evidence was submitted that challenged the validity of the test results. Therefore, I find that the April 25, 2005 pulmonary function test is valid.

October 10, 2005 Pulmonary Function Study

This study produced values that were non-qualifying under the regulations. § 718.204(b)(2)(i). The pulmonary function report contained the required flow-volume loop and tracings and a notation that Claimant's efforts were acceptable. Additionally, no evidence was submitted that challenged the validity of the test results. Therefore, I find that the October 10, 2005 pulmonary function test is valid.

In sum, I find that the weight of the pulmonary function study evidence does not support a finding of total disability pursuant to § 718.204(b)(2)(i).

The current record contains the arterial blood gas studies summarized below.

DATE	EX. NO.	PHYSICIAN	PCO2	PO2	QUALIFIES
04/25/05	DX 10	Dr. Khan	34.9 33.4*	70 41.9*	No Yes*
10/10/05	EX 1	Dr. Goldstein	42	65	No

*post-exercise

The April 25, 2005 post-exercise blood gas study did yield qualifying results. This result supports a finding of total disability under the provisions of § 718.204(b)(2)(ii).

Under § 718.204(b)(2)(iii), total disability can also be established where the miner had pneumoconiosis and the medical evidence shows that he suffers from cor pulmonale with right-sided congestive heart failure. There is no record evidence of cor pulmonale with right-sided congestive heart failure.

The remaining means of establishing total disability is with the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful work. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv).

The record contains the following medical opinions regarding total disability.

Dr. Khan

In his May 25, 2005 report, Dr. Khan opined that Claimant does not have the respiratory capacity to perform his last coal mine employment. The physician noted that Claimant's pulmonary function test results showed a restrictive lung disease and impaired membrane function. Additionally, Dr. Khan stated Claimant's arterial blood gas study showed significant hypoxemia after exercise. (DX 10).

Dr. Goldstein

In his November 3, 2005 report, Dr. Goldstein noted he found rales bilaterally at both bases of the lungs during Claimant's physical examination. Additionally, Dr. Goldstein stated that Claimant's pulmonary functions are restrictive and he has an abnormal diffusion capacity. The physician concluded that Claimant has a significant respiratory impairment that would not allow him to return to his previous coal mine employment. (EX 1).

Dr. Russakoff

After reviewing Claimant's prior medical records, Dr. Russakoff noted that Claimant's pulmonary function tests demonstrate a moderate to severe restrictive ventilatory impairment. The physician also saw evidence of impairment in oxygen transfer. Based on Claimant's need for supplemental oxygen, abnormal pulmonary function tests, and chest X-ray's, Dr. Russakoff diagnosed Claimant with a significant pulmonary impairment. The physician opined that Claimant is totally disabled from a pulmonary standpoint. (EX 4).

I find that Dr. Khan's opinion is well-documented and reasoned. See Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987); Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295 (1984). Dr. Khan relied on Claimant's physical examination, chest X-ray, and objective medical testing in reaching his conclusion. Therefore, I find Dr. Khan's opinion that Claimant is totally disabled is entitled to substantial weight.

I also find that Dr. Goldstein's opinion is reasoned and well-documented. Dr. Goldstein based his conclusion on the physical examination, chest X-ray, pulmonary function tests, and prior medical records. Therefore, I find Dr. Goldstein's opinion that Claimant is totally disabled is entitled to substantial weight.

Finally, I find Dr. Russakoff's opinion is reasoned and well-documented. Dr. Russakoff reviewed Claimant's extensive medical records, objective medical testing results, and chest X-rays in reaching his conclusion. Therefore, I find Dr. Russakoff's opinion that Claimant is totally disabled is entitled to substantial weight.

As previously discussed, the pulmonary function tests do not establish total disability. However, the April 25, 2005 post-exercise arterial blood gas study does support a finding of total disability. Additionally, the uncontradicted medical opinion evidence supports a finding of total disability. Based on the foregoing, Claimant has established this element of entitlement.

4. Total Disability Due to Pneumoconiosis

As Claimant has failed to establish the presence of pneumoconiosis under § 718.202(a), Claimant cannot establish total disability due to pneumoconiosis under § 718.204(c)(2).

F. Conclusion

As Claimant has not established all elements of entitlement, the claim must be denied.

ATTORNEY FEE

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

ORDER

The claim of E.A. for benefits under the Act is DENIED.

A

Robert D. Kaplan
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).